Seaman Family Dentistry
CREATING HEALTHY YOUNG SMILES APPLICATION

RESPONSIBLE PARTY CONTACT INFORMATION

Full Name:			
Street Address:	City, State:		Zip:
Cell Phone:	Hm Phone:	Wk Phone:	X
Email:			
Social Sec. No.:		ID/DL#:	State:
Other ID (if neither of the above):			
Relationship to Patients:	People in Household: Total #:	# Children:	# Adults:

HOUSEHOLD INCOME SECTION

List Each Adult (18 & over) Living in Household, Their Work Status, and Either Net or Gross Income:

Adult 1 (from above): Works?: □Yes □No □Disabled

Net Income: $_____ □Weekly □Bi-Weekly □Monthly OR Gross Income: $_____ □Weekly □Bi-Weekly □Monthly

Adult 2: Rel. to Adult 1: Works?: □Yes □No □Disabled

Net Income: $_____ □Weekly □Bi-Weekly □Monthly OR Gross Income: $_____ □Weekly □Bi-Weekly □Monthly

Adult 3: Rel. to Adult 1: Works?: □Yes □No □Disabled

Net Income: $_____ □Weekly □Bi-Weekly □Monthly OR Gross Income: $_____ □Weekly □Bi-Weekly □Monthly

Adult 4: Rel. to Adult 1: Works?: □Yes □No □Disabled

Net Income: $_____ □Weekly □Bi-Weekly □Monthly OR Gross Income: $_____ □Weekly □Bi-Weekly □Monthly

Are there additional adults living in the home? □YES □NO If yes, ask for an additional income earner page to attach.

CHILDREN LIVING IN THE HOME

List each child (under 18 years) living in the home:

Child 1: DOB: / / Age: Rel. To Resp. Party:

Child's Needs: □ General Dental Care □ One-Time Emergency Dental Care □ Only Orthodontic Assistance

Child 2: DOB: / / Age: Rel. To Resp. Party:

Child's Needs: □ General Dental Care □ One-Time Emergency Dental Care □ Only Orthodontic Assistance

Child 3: DOB: / / Age: Rel. To Resp. Party:

Child's Needs: □ General Dental Care □ One-Time Emergency Dental Care □ Only Orthodontic Assistance

Child 4: DOB: / / Age: Rel. To Resp. Party:

Child's Needs: □ General Dental Care □ One-Time Emergency Dental Care □ Only Orthodontic Assistance

Child 5: DOB: / / Age: Rel. To Resp. Party:

Child's Needs: □ General Dental Care □ One-Time Emergency Dental Care □ Only Orthodontic Assistance

Child 6: DOB: / / Age: Rel. To Resp. Party:

Child's Needs: □ General Dental Care □ One-Time Emergency Dental Care □ Only Orthodontic Assistance

Are there any other children under 18 living in this home? □ Yes □ No If yes, ask for an additional child page to attach.

ADDITIONAL INCOME

Does anyone in the home receive money or food stamps from the government? □ Yes □ No

If yes, what is the total amount received by all household members each month? $ per month

Does anyone in the household receive child support or alimony payments? □ Yes □ No

If yes, what is the total amount received by all household members each month? $ per month

Does the household receive any other type of monthly income not listed previously? □ Yes □ No

If yes, what is the total amount received by all household members each month? $ per month

PROOF OF INCOME – TO ATTACH TO APPLICATION

For **each** working adult in the household attach proof of income.

Acceptable forms of proof: Copy of most recent tax return, pay stubs showing the past month of income, a signed statement of wages from employer, or a copy of bank statements showing income deposits for the past 2 months.

OTHER DENTAL CARE ASSISTANCE

Is anyone in the household covered by any dental insurance plan? □ Yes □ No

If yes, list each covered member:

Are any of the children in the home eligible for coverage under a dental plan? □ Yes □ No

If yes, which child(ren)?

Are any children in the household covered by a government health or dental plan? □ Yes □ No

If yes, which child(ren)? What Plan?

Have you applied for Federal or State Dental Benefits for any children on the application? □ Yes □ No

If yes, which program? Status of Application: □ Approved □ Pending □ Declined

AGREEMENT TERMS

By signing below….

1. I certify that all the information provided above or attached is true and correct.
2. I request that my children be considered for participation in the Creating Healthy Young Smiles Program.
3. I understand that if my children are accepted, it is not permanent and I will need to re-apply at the specified time frame on the acceptance letter.
4. I understand that my children need to keep all scheduled appointments or contact the office no less than 72 hours before the appointment to reschedule. Unless there is an actual emergency causing shorter notice.
5. I understand that if I fail to confirm any appointments which were scheduled more than a month in advance, by the week before the scheduled appointment, my child's appointment will be removed from the schedule.
6. I agree to keep my phone number(s), address, and any email addresses current with the office so I may be reached to confirm or schedule my children's appointments.
7. I understand and agree to always have an adult with my children at every dental appointment who can make dental care decisions for my child.
8. I understand that if my children are approved for a plan in this program that it is still my responsibility to be informed about their dental needs and treatment options and that it is still up to me or their other parent/guardian, what services are provided to my child(ren) or to the adult I appoint this responsibility to.

SIGNATURE

Responsible Party Signature: Date:

THE SECTION BELOW IS FOR OFFICE USE ONLY

Staff Member Reviewing Application:	Date Reviewed:
Total Monthly Income From Household Income Section (converted to Gross Income – use wage documents to covert net pay to gross amounts before adding):	$ gross income
Total of All Additional Income in the Household: $ per month Total of Gross Monthly Household Income: $ per month Combined Total Monthly Income: $ X 12 = $	Yearly Gross Income
Total Adults: Total Children: Total Household Members:	Over Income Guide: □Yes □No
# Adults covered by insurance:	# of children covered by or eligible for insurance?
# of children declined by Fed/State programs:	Any Pending Assistance?: □Yes □No
Special Circumstances:	
Plan Recommendation: □None □Plan A □Plan B □Plan C	Length: □Temp □3 mos □Annual
Adult Discount Recommendation: □None □Plan A □Plan B	Length: □Temp □3 mos □Annual

FINAL REVIEW AND APPROVAL

Plan Recommendation: □None □Plan A □Plan B □Plan C	Length: □Temp □3 mos □Annual
Adult Discount Recommendation: □None □Plan A □Plan B	Length: □Temp □3 mos □Annual
OTHER:	Date Letter Sent:_____
Office Manger Signature:	Date: